State of California

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M e m o r a n d u m

To: Chris Stottlemyer, Administrator
Braswell's Hampton Manor

Date: October 19, 2011

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From: Operation Guardians
Bureau of Medi-Cal Fraud and Elder Abuse - Sacramento
Office of the Attorney General

Subject: Operation Guardians Inspection

On September 13, 2011, the Operation Guardians team conducted a surprise inspection of Braswell's Hampton Manor in Yucaipa. The following summary is based upon the team's observations, plus documents and information provided by the facility.

SUMMARY OF RESIDENT CARE FINDINGS:

1. The team observed the breakfast trays arrive to the floors at approximately 8:00 AM. Most of the residents were observed in bed and were improperly positioned for eating the morning meal. Several of the residents were slumped down in the bed while others had not been awakened. We observed food trays had been delivered to the bedside and left for the food to become cold. At 8:30 AM many residents who required feeding were still waiting on assistance for the meal. Most of the licensed staff were observed talking and sitting at the nursing station. When the RN in charge at the desk was asked by the Operation Guardians (OG) nurse when the residents were going to be fed, she replied "What time did the trays arrive?" Only when the team nurse mentioned the food was getting cold, did the licensed staff get up to assist the residents.

2. A CNA reported there were two assistants assigned to each hall but only one CNA was observed remaining on each unit to assist in feeding residents breakfast. The other CNA was assigned to the dining room. The CNA reported she had five residents who required to be fed breakfast on her hall. The team had concerns that this poor practice compromises the resident's ability to receive the necessary nourishment and hydration.

3. The medical record review of Resident 11-01-01 indicated she had lost nine (9) pounds in one month as her current weight was recorded by the facility at 94 pounds. The physician orders indicated she was to receive House Nourishment three times a day (TID). According to the dietician's evaluation, the resident ***"does not like Healthy Shakes."*** The resident was observed asleep in bed with her breakfast food tray uncovered and her food had been cut up for her. Her roommate reported to the team nurse the resident required assistance by the staff with eating. It should also be noted the resident's tray was observed with ***Healthy Shakes***.

4. Resident 11-01-02 was first observed at 8:30AM lying in bed on his right side with the head of the bed (HOB) elevated approximately 45 degrees. The resident's diagnosis included: mental retardation, Cerebral Palsy, nonverbal, gastrostomy tube, dysphagia, contractures of the hands and legs, seizures and Crohns Disease. The Operation Guardians (OG) nurse observed the resident's position every 30 minutes to see if he was being turned on a routine basis. His medical

chart was reviewed to see what his turning schedule was and when he was to be up in his wheelchair. The OG nurse noted that the resident was turned to his left side between 9:30AM and 10:00 AM. The resident was not turned again until 2:15 PM (more than 4 hours after his last position change.) Due to the resident's medical condition he was not able to reposition himself. He was at a high risk for skin breakdown due to pressure and possible shearing from having the HOB elevated to decrease the risk of aspiration from his GT feedings.

Resident's care plans (CP) were reviewed and most were pre-printed and only minimal additions were noted to individualize for this specific resident. A care plan with the heading "Risk for Skin Breakdown" had multiple interventions checked off. The only intervention that addressed change of position said "*Assist with repositioning as needed."* There was no individualization of the care plan to indicate what specific nursing interventions were to be implemented since the resident was not able to assist with repositioning nor could he ask to be repositioned. The OG nurse was unable to find any schedule for turning in the medical chart or at the bedside. Another care plan called "ADL Function" had an intervention checked which stated "*Assist in turning, repositioning as per schedule."* This CP did not indicate what the schedule was or where it could be found.

The resident was not moved into his wheelchair the entire time the OG team was in the facility. No chart documentation could be found that stated when or how long he was to be up in his wheelchair.

5. Resident 11-01-03 was observed in bed. He was on oxygen via a nasal cannula. The concentrator was viewed for the flow rate. It was set at 4L/min. and there was no humidifier attached to the concentrator. He had a Foley catheter that was lying on the floor. He had a hospital bracelet on his left wrist from "Redlands Community Hospital". His medical record was reviewed and the only FACE sheet discovered in the medical chart was labeled "Redlands Community Hospital" and the document indicated he had been discharged from acute care on September 3, 2011 or ten (10) days earlier.

   The Director of Nurses (DON) was interviewed about when humidifiers were to be placed on the oxygen equipment. She stated that humidifiers were only provided "when needed." The*" Policy and Procedure for Oxygen Administration"*was reviewed and it stated that humidifiers were to be on all oxygen over 4L/min and as needed. The facility's policy and procedure was not being adhered to.

6. Resident 404A was interviewed in her room. She was on oxygen via a concentrator at 3L/min. There wasn't a humidifier connected to the oxygen cannula. She reported that she had experienced a very dry nose in the past and had asked to have a humidifier, however, one had not been provided for her. She reported at this time she was not having a problem.

FACILITY ENVIRONMENTAL OBSERVATIONS:

1. The building was observed with filthy carpets and flooring in the resident rooms and throughout the facility. The flooring in the facility was also extremely worn with cracks in the vinyl. The floors in the storage areas such as the oxygen room were dirty and required deep cleaning. The

floors in the resident bathrooms and showers had anti-skid strips applied at some date but the strips were observed curling up or had come off leaving a sticky area. This can be a safety hazard for residents.

2. A dinner tray was found left on a table in the main dining room. Residents were positioned at the table waiting for their breakfast trays to be delivered with the left-over food tray remaining in the room.

3. The temperature in the building was cold. Many residents complained of the cold temperatures and were observed dressed in sweaters, jackets and blankets. Residents stated it was "always cold" and they never had enough blankets to keep them warm. The temperature inside the building remained cold throughout the entire inspection time.

4. Residents' urinals, bedpans, toothbrushes, and emesis basins, observed in the bathrooms were not identified with a name. This is a health and safety issue for the facility residents.

5. The medication and wound treatment carts were observed to be filthy and required deep cleaning to the outside of the carts. The ledge along the bottom of all carts had a layer of ground in dirt.

6. The pay telephone by the social dining room was non-operational.

7. The water fountain was soiled and required deep cleaning.

8. Call lights were observed out of reach of the residents and several lights were found on the floor and behind the beds on the floor. When call lights were activated the response time of the nursing staff was slow and unacceptable to provide quality care. Many residents complained to the team when their light was activated the staff were slow to respond and when they responded the light would be turned off and they would be told they would be right back, and would often not return.

9. Water cups and pitchers were observed out of reach for the facility residents. This compromises the resident's ability to stay hydrated. This is a quality of care issue.

10. Residents throughout the facility appeared unkept. Women needed their hair combed and men required shaving. Many of the residents were wearing soiled clothing and appeared depressed and distressed.

11. Walls in some of the resident's rooms had large areas of wall paper that was peeling or appeared to have been scraped off.

ADMINISTRATIVE OBSERVATIONS:

1. The Director Of Nurses (DON) had been employed at the facility for three months and could not recall the management staff's names.

2. The Administrator and DON could not identify the name of the President of the Resident Council.

3. During medical chart review and review of the facility infection control log, it appeared that the facility did not have an effective procedure in place to track residents with C-Difficile infections. Residents identified in the 24- hour log with the infection and those recorded on the log did not correlate with the team's findings. This can jeopardize the health and safety of the facility residents.

   The resident residing in Room 206 B was identified as having an infection only by the fact an isolation cart was in place at the door leading into her room. Her medical chart indicated she had been tested for C- Difficile and a negative stool laboratory test had not yet been recorded. This resident was observed by the team in the Occupational Therapy (OT) room with other facility residents. When the charge nurse was asked about the resident's current status she reported the resident was currently having diarrhea. The team nurse inquired why the resident was attending OT in the therapy room with other residents. The facility nurse explained the OT staff would disinfect all the equipment after the resident's use during her group therapy. Later, the facility nurses reported the resident was not having loose stools and they were confusing this resident with another resident.

   A copy of the facility's *"Policy and Procedure for Infection Control*" was presented to the team reviewed. The policy was generic for infection control and did not include specific nursing procedures for C-Difficile infections. The DON was questioned regarding the Infection Control Policy and the team was then presented with the California Association of Health Facilities (CAHF) publication "*Joint Infection Prevention and Control Guidelines,"* dated 2010. It was unclear if this guide was being used as this facility's policy and procedure for infection control. The facility's lack of implemention of a precise and strict infection control plan places not only the residents at a health and safety risk, but visitors to the facility as well.

4. Resident's complained they did not receive enough meat with their breakfast meals. The team nurses reviewed the posted facility menus and confirmed that meat was only offered to the residents twice a week.

5. Many of the facility staff were not wearing name tags. They were observed with their name written on a piece of tape applied to their uniforms. This is a violation of Title 22 Regulations.

6. Several residents complained of valuables missing. One resident specifically said that she "couldn't even leave her puzzle books or magazines in her room when she left, because they would be gone upon her return." She was very upset about the facility's lack of concern about these missing items, and said it happened on a regular basis to her and other residents.

7. Review of the facility's "Resident Abuse Investigation Policy and Procedures" revealed the policy was not in compliance with California state law. The individual that witnesses or suspects abuse or neglect is required to fill out an SOC 341 form, not the Administrator. An individual facility's investigation into possible abuse is completely separate from what is required under California law. Any employee of a facility can be charged with a "failure to report" for failing to follow this law. We would suggest that the Administrator and staff review the Department of Justice mandated training materials and video entitled "Your Legal Duty: Reporting Elder and Dependent Adult Abuse."

STAFFING:

Based on the July and August 2011 records provided by the facility, **staffing levels were below the 3.2 hours per resident day (hprd) on two of the six days randomly reviewed.**

CONCLUSION:

Please be advised that this is a summary of information available to us at this time. Should further information develop from the efforts of Operation Guardians, we will notify you at the appropriate time.

The Operation Guardians inspection does not preclude any Department of Health Services complaint or annual visits, any law enforcement investigation or other licensing agency investigation or inspections, which may occur in the future. A copy of this report is being forwarded as a complaint to the Department of Health Services. This inspection does not preclude any further Operation Guardians unannounced inspection.

We do not require that you submit a plan of correction regarding the findings of the Operation Guardians inspection. However, at some future time, the contents of this letter may be released to the public.

We encourage your comments so they can be part of the public record as well. Please send any comments to, Cathy Long NEII, at 1425 River Park Drive, Sacramento, California 95815, phone: (916) 274-2913.

Physician's Report – Operation Guardians
Kathryn Locatell, MD
October 24, 2011

Braswell's Hampton Manor
September 13, 2011

I. Summary

The care of fifteen current or former residents was reviewed. In addition, we conducted direct observation of residents and resident care, reviewed a variety of documents on site and interviewed the director of nurses and other staff. There were deficient facility practices in the areas of infection control, end of life care, nutrition and hydration care, and nursing services, in particular licensed nurse assessment and monitoring. Residents at this nursing facility are being avoidably harmed due to these deficient practices.

II. Infection control

The facility lacks an effective process for monitoring, preventing, recognizing and treating infections. This was especially notable given the recent large numbers of residents suffering from *Clostridium difficile* ("c. diff") infections, which may indicate that these infections spread in the facility because of inadequate infection control.

Resident 4 was identified through review of the licensed nurse communication book. A nurse wrote that the resident had experienced 2 episodes of loose stools on 9/1/11. Subsequent to that entry, there was no tracking of the resident's bowel movements, either in the communication book or in the narrative nurses' notes contained in her medical record. The resident had been admitted to the facility from an acute care hospital for rehabilitation following treatment of a urinary tract infection and had been receiving antibiotic therapy, which greatly increases the chances of contracting c. diff. Although it was not documented by any licensed nurses, the bowel record for Resident 4 showed that CNAs had charted that she had been having loose stools on an almost daily basis since 9/1/11. In addition, the resident had been eating and drinking poorly, had lost a significant amount of weight, required intravenous fluid administration, and was not making progress toward her goal of retuning home. Furthermore, there was confusion among the staff regarding the proper infection control process for a resident potentially infected with c. diff. She was receiving therapy with other residents on the morning of our inspection, with no infection control measures having been taken by therapy staff; staff present at the time were unaware that Resident 4 might have had c. diff.

Another resident (Resident 1) had been diagnosed with c. diff on 7/17/11. However, on review of the infection control logs, this resident was not listed and had not been identified as a case of c. diff that month. The Director of Staff Development, in charge of

infection control, was asked about Resident 1 and stated she "must have missed it." The process she used to identify and track infection was a daily review of new orders for all residents in the facility, which in my opinion is cumbersome and likely to lead to missed infection events as in this case.

The infection control logs also showed that there had been a 2- to 3-fold rise in the numbers of residents infected with c. diff in the past 3 months in comparison with earlier months this year. The medical director stated that c. diff "is rampant in the community" but was unaware of the rise in c. diff cases in this nursing home, and was unaware that her patient, Resident 4, had been having loose stools almost daily since 9/1. She had ordered stool testing for c. diff for Resident 4 two days earlier but the sample had not been sent to the laboratory. She declined to start empiric therapy for Resident 4, even after being informed of the deficient practices identified during our inspection.

A number of residents among the 15 reviewed were found to have developed urinary tract infections. There was an apparent pattern of failure to detect and treat these infections timely. For example, Resident 5 exhibited an increase in agitated behaviors on 8/18/11. There was no nursing assessment of potential causes, such as a urinary tract infection. The licensed nurse obtained telephone orders to increase the dosage of both lorazepam (benzodiazepine tranquilizer) and transdermal fentanyl (long-acting opioid analgesic) on that date. Subsequently, there was little monitoring of Resident 5's condition but on 9/6/11 she was found to be lethargic with altered mental status and was sent to the emergency department where she was diagnosed with a urinary tract infection. Had nurses considered that a UTI was a likely cause for her increased behaviors, the infection would have been diagnosed and treated sooner; likely the resident would not have needed the increased medications and would not have needed to go to the emergency department.

In another case similar case, Resident 10 suffered a fall on 7/13/11. There was no nursing assessment as to potential causes, such as a urinary tract infection. During the every-shift post fall monitoring, no nurse noticed anything amiss with Resident 10. However, on the 4th day after the fall (after the every-shift charting was "complete"[1]), a nurse documented that Resident 10 was "staring", "pale", and "refusing meds and most meals lately, not acting herself the past couple of days or so", which prompted the nurse to request a urinalysis and culture. Over the next two days, the resident continued to appear lethargic, refusing medications and meals; she was sent to the hospital on 7/20, where she was diagnosed with dehydration and a urinary tract infection; despite treatment with intravenous antibiotics and fluids, she died in the facility on 7/25/11. In this case, there was a delay in the facility's recognition of the UTI, which led to a delay in treatment and also avoidable dehydration, both of which contributed to the resident's death.

In another example, a licensed nurse documented in the narrative nursing notes on 8/3/11 that Resident 8 "constantly asked to go to the restroom and was unable to urinate. Res. shows signs of increase [sic] confusion…Appears aggitated [sic], due to confusion." A

[1] Licensed nurses are required (usually by facility policy) to assess a resident every shift after a change of condition for a minimum of three days or until the change of condition has resolved.

urinalysis was sent to the laboratory the next morning and showed indicators of a urinary tract infection. However, no nurse followed up and obtained the urine culture report. On 8/15, Resident 8 was found on the floor and was extremely agitated; subsequently she was given an intramuscular injection of lorazepam and continued in various states of agitation over the next two days. On the evening of 8/17, she was found on the floor again and had broken her left hip and right hand and was hospitalized. She returned to the facility on hospice care, as her condition was too poor to warrant surgical treatment of the hip fracture; she died at the facility on 8/27/11.

The 8/4/11 urine culture report was not found in Resident 8's closed record, but upon request, the facility did obtain a copy of it from the lab. She had an *Enterococcus* urinary tract infection, and the date of the culture report was 8/6/11. In my opinion, Resident 8 was suffering from this infection continuously from 8/3, and the infection was likely the cause of the resident's agitation and falls. The failure of the facility to obtain this report and act on it timely substantially contributed to Resident 8's death.

With respect to both urinary tract and c. diff infections, prevention and treatment are simple and effective. Both require CNAs to provide adequate perineal hygiene, and to maintain the cleanliness of residents' belongings, rooms and bathrooms. CNAs must practice good handwashing, consistently. It does not appear that the facility is providing adequate CNA staffing to ensure that these preventable infections do not occur. On the day of our inspection, CNAs were assigned 11-12 residents each, which workload makes it impossible to provide this essential care to every resident on a consistent basis. In addition, the facility appeared unclean, with visible dried feces on walls of bathrooms and showers observed during a walk-through.

III. End of life care

The facility cares for a relatively large proportion of hospice residents, approximately 15% of the census on the day of our inspection. Among the recent deaths reviewed, 9 were hospice residents. Thus the quality of end of life care provided at the facility is potentially important to a large number of residents. However, I found many aspects that did not meet generally accepted standards of quality.

Notable among the hospice residents whose charts I reviewed was the relative high acuity of their treatment regimens. Several were receiving tube feedings; in addition to the frequent monitoring of and medicating for end of life symptoms, tube feeding poses additional, time-consuming tasks for licensed nurses. In the case of Resident 3, it did not appear that nurses were adequately monitoring the resident's tube feeding. There was a week-long gap in narrative charting, between 8/16 and 8/23/11, and both entries on those dates were by a visiting hospice nurse. The hospice nurse noted on the morning of 8/23 that the resident had a "wet cough" and was "vomiting yellow thick sputum" whereas no facility nurse had charted anything about the resident's condition for more than a week prior. The resident died about 24 hours later of what was clearly an aspiration pneumonia. Considering the short time frame between death and when the hospice nurse

noted symptoms, it is unlikely that Resident 3's condition changed suddenly on the morning of 8/23. More likely, licensed staff did not assess or document any changes for days prior, or perhaps failed to note them at all, in a substantial breach of prevailing standards.

In another case, Resident 14, who was receiving tube feedings, experienced recurrent vomiting over the month prior to his death on 8/14/11. Vomiting was first noticed on 7/7/11; at that time he was receiving "bolus" feedings, which were ordered held for 3 days, during which time there was no vomiting. Feedings were resumed but vomiting recurred and persisted, even after the resident was placed on continuous feedings. There is no evidence that facility nurses assessed the reasons for his intolerance of the feedings, or that the rationale for continuing artificial feeding at all was discussed with hospice staff or the resident's family. In my opinion, this resident's comfort was compromised by the facility's failure to properly manage his intolerance of the feedings.

Residents receiving hospice services commonly require very active nursing interventions, especially as they approach death, with the need for more frequent assessments and heightened interventions to ensure comfort. In several cases reviewed, evidence of active nursing involvement as the resident was dying was lacking. In particular, in Resident 12's case, nurses failed to provide care to a severe tongue injury. The resident experienced two seizures on 7/3/11, 2 days before his death. During the second seizure that day, it was evident that the resident had bitten his tongue; blood was observed in his mouth and his tongue was "extremely swelled up". There was no assessment of the condition of the tongue, whether it was painful to the resident, whether mouth care was delivered or not, for the remaining hours of the resident's life. In my opinion, a lacerated tongue is extremely painful, even to a dying person or perhaps especially to a dying person, and the resident deserved management of the condition, yet none was provided. It would have been a simple matter for nurses to have administered an anesthetic solution to relieve any discomfort and prior to providing oral care to ensure that he did not needlessly suffer.

IV. Nursing services and processes of care

A number of deficient practices were identified during the one-day inspection. First, as noted above, the facility does not appear to be providing sufficient nursing staff to meet the needs of residents. The staffing ratio for CNAs on the day of our inspection was insufficient to meet the needs of the residents. It is virtually impossible that a CNA can meet the needs of 10 or more residents on the day shift. Visible evidence of lacking basic care included residents appearing poorly groomed, in soiled clothing; and lined up in hallways, slumped in wheelchairs, asleep. Lacking basic bedside care was also evident in the numbers of c. diff and urinary tract infections, falls, weight loss and dehydration, observed in residents' medical records. The acuity of the facility's residents appeared to be higher than average, with many residents on hospice and receiving tube feedings, as well as many residents being transferred back and forth to acute care hospitals.

Licensed nursing staff also appears to be insufficient. There were gross lapses in nursing assessment and monitoring, as noted in the cases described above. The process by which nurses ensure continuity of care across shifts is not effective, with licensed nurses failing to follow up on simple tasks such as monitoring a resident's bowel movements or obtaining a urine culture report from the lab. On the day of this inspection, residents of this facility were at risk for harm from these deficient practices.